

CLIENT INFORMATION:

Today's Date: _____

Name: _____
Last name, first name

Date of Birth: _____

Home Address: _____

Soc. Sec. No. _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Which number should be called if it is necessary to change an appointment or leave a message? Home Work Cell**EMPLOYEE INFORMATION:**

Employer Providing Coverage: _____

Health Insurance Company: _____ Phone No: _____

Employee Name: _____ Employee Soc. Sec. No. _____

Employee Insurance ID Number: _____ Employee Date of Birth: _____

Client Relationship to Employee: _____

PSYCHOSOCIAL HISTORY QUESTIONNAIRE*All questions contained in this questionnaire are strictly confidential and will become part of your record.***CURRENT CONCERNS**

Briefly describe the problem you would like to address:			
What do you expect from treatment?			
Were you referred to this office? By Whom?		How did you find out about this office?	

PERSONAL HEALTH HISTORY

Name of Primary Care Physician:	Phone:	Fax:	Date of last visit:

Please check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

<input type="checkbox"/> Skin	<input type="checkbox"/> Chest/Heart/Circulation	Recent changes in:
<input type="checkbox"/> Head/Neck	<input type="checkbox"/> Bladder/Bowel	<input type="checkbox"/> Weight
<input type="checkbox"/> Ears/Nose/Throat	<input type="checkbox"/> Intestinal	<input type="checkbox"/> Energy level
<input type="checkbox"/> Lungs	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Ability to sleep

Please list any medical problems that doctors/medical providers have diagnosed:**List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers (use other side of page if needed)**

Name the Drug (Prescriber if different than your primary physician)	Strength/Dose	Frequency Taken	Outcome since starting the medication		
			<input type="checkbox"/> Better	<input type="checkbox"/> Worse	<input type="checkbox"/> Same
			<input type="checkbox"/> Better	<input type="checkbox"/> Worse	<input type="checkbox"/> Same

Allergies to medications/food/environment (use other side of page if needed)

Name the allergen (drug/food/environment)	Reaction You Experience

Childhood illness:	<input type="checkbox"/> Measles <input type="checkbox"/> Mumps <input type="checkbox"/> Rubella <input type="checkbox"/> Chickenpox <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Polio <input type="checkbox"/> Other: _____
	<input type="checkbox"/> Developmental problems or Genetic Disorders Specify: _____

Surgeries (use other side of page if needed)

Year	Reason	Hospital	Outcome since surgery		
			<input type="checkbox"/> Better	<input type="checkbox"/> Worse	<input type="checkbox"/> Same
			<input type="checkbox"/> Better	<input type="checkbox"/> Worse	<input type="checkbox"/> Same

Other hospitalizations (include inpatient/outpatient chemical dependency, psychiatric services, use other side of page if needed)

Year	Reason	Hospital	Outcome since Hospitalization		
			<input type="checkbox"/> Better	<input type="checkbox"/> Worse	<input type="checkbox"/> Same
			<input type="checkbox"/> Better	<input type="checkbox"/> Worse	<input type="checkbox"/> Same

SPIRITUAL ASSESSMENT

Do you consider yourself spiritual or religious? Yes No I choose not to answer

Are you part of a spiritual or religious community? Yes No I choose not to answer
 If **YES**, please indicate your Faith/Religion/Spiritual Affiliation: _____

How important is your faith or spiritual/cultural beliefs to you in life? (place a check in the corresponding box)

<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="checkbox"/> 10
No Opinion	Not Important At All		Not Very Important		Mildly Important			Very Important	

How have your beliefs or practices influenced how you take care of yourself during illnesses or during difficult times? _____ I choose not to answer

Would you like your counselor to address these issues in your treatment? Yes No need to address I choose not to answer

HEALTH HABITS AND PERSONAL SAFETY

Exercise (check one)

Sedentary (No exercise) Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)

Mild exercise (i.e., climb stairs, walk 3 blocks, golf) Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)

Diet

Are you dieting? Yes No

If yes, are you on a physician prescribed medical diet? _____ Yes No

Number of meals you eat in an average day? _____

Caffeine

None Coffee Tea Cola/Soda

Number of cups/cans per day? _____

Alcohol

Do you drink alcohol? Yes No

If yes, what kind? _____ How many drinks per week? _____

Have you ever experienced blackouts? Yes No

Are you prone to "binge" drinking? Yes No

Do you drive after drinking? Yes No

Have you been arrested while driving under the influence of alcohol or drugs? Yes No

Tobacco

Do you use tobacco? If yes, how much/day? _____ Yes No

Number of years (How Long?) _____ Or year quit _____

Drugs

Do you currently use recreational or street drugs? Yes No

Have you ever given yourself street drugs with a needle? Yes No

Sex

Are you sexually active? Yes No

If yes, are you trying for a pregnancy? Yes No

If not trying for a pregnancy list contraceptive or barrier method used: _____

Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness? Yes No

Personal Safety

Physical and mental abuse have become major public health issues in this country. This often takes the form of verbal threats or actual physical or sexual abuse. Would you like to discuss this issue with your clinician? Yes No

Education and

Did you receive a diploma or GED? Highest degree awarded: _____ Yes No

Did you attend Special Education classes? Yes No

Occupation	Did you experience any learning difficulties during school?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
	Are you currently employed? Position & Employer: _____	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
	What is your current source of income? _____	<input type="checkbox"/> No Income			

FAMILY HEALTH HISTORY (please use other side of page if needed)

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			Children	<input type="checkbox"/> M	
				<input type="checkbox"/> F	
Mother			<input type="checkbox"/> M		
			<input type="checkbox"/> F		
Siblings	<input type="checkbox"/> M <input type="checkbox"/> F		Grandmother <i>Maternal</i>		
	<input type="checkbox"/> M <input type="checkbox"/> F		Grandfather <i>Maternal</i>		
	<input type="checkbox"/> M <input type="checkbox"/> F		Grandmother <i>Paternal</i>		
	<input type="checkbox"/> M <input type="checkbox"/> F		Grandfather <i>Paternal</i>		

PAIN SCREENING

Are you currently experiencing pain? Yes No

If "Yes" is this pain chronic? Yes No Where is your pain located? _____

On a scale of one to ten please indicate how severe you feel this pain is **today** (1 is the least 10 is the most).
 1 2 3 4 5 6 7 8 9 10
(Little or no pain.....Moderate Pain.....Severe Pain)

SYMPTOM REVIEW

Have you been consistently depressed or down, most of the day, nearly every day, for the past two weeks?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Have you felt sad, low or depressed for the past two years?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Are you feeling suicidal?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Have you ever attempted suicide?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Have you ever had a period of time when you were feeling "up" or "high" or so full of energy that you got into trouble or that other people thought you were not your normal self?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Have you been feeling irritable, or do you find yourself frequently starting fights with other people?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Have you, on more than one occasion, had spells or attacks when you suddenly felt anxious, frightened, uncomfortable or uneasy, even in situations where most people would not feel that way?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Have you ever felt anxiety or panic when you were in a crowd, standing in a line or while alone in your car, crossing a bridge or traveling by airplane, train, bus or car?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
In the past month, were you fearful or embarrassed about being watched, the focus of attention, or fearful of being humiliated? This includes times like speaking in public, eating in public or with others, writing while someone watches, or in social situations?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
In the past months have you been bothered by recurrent thoughts, impulses or images that were unwanted, distasteful, inappropriate, intrusive or distressing? (For example, the idea you were dirty, contaminated or had germs.)	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Do you experience frequent or recurrent nightmares?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Have you ever experienced or witnessed or had to deal with an extremely traumatic event that included actual or threatened death or serious injury to you or someone else?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Have you ever experienced abuse (physical, sexual, verbal) or neglect?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Have you ever believed that people were spying on you, or conspiring against you?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Have you ever believed that someone was reading your mind, or that you could read someone's mind, or hear what another person was thinking?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Do you have difficulty sitting still or paying attention? Are you easily distracted, find yourself daydreaming or "spacing off."	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No

Additional comments or information you think is important: (use other side of page if needed)

Thank you for completing this survey!

DOCUMENT REVIEWED BY: _____ DATE: _____